

Fair Treatment Notice

SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

- > Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- > Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at **1-800-538-5038** (TTY Users: 711)

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **1-800-538-5038**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'de'ę', t'áá jiik'eh, éí ná hółq', kojí' hódíílnih SelectHealth: **1-800-538-5038**.

ध्यान दनुहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमितिभाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

تدعاسملا تامدخ نإف، ةيبرعلا ثدحتت تنك اذا: ةظوحلم
ةكشرشب ل لصتا. ن اجملاب كل رفاوتت ةيوعلل
SelectHealth: **1-800-538-5038**.

សម្ពាសៈ បីសិនជាអ្នកនិយាយ ភាសាខ្មែរ
ស្រីវ៉ាជំនួយជូនកុំភាសា ជាយមិនគិតថ្លៃ
គម្រោងមានសរាប់ អ្នកក៏ សូមទូរស័ព្ទមក
SelectHealth: **1-800-538-5038** ។

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**。まで、お電話にてご連絡ください。

Individual Plans Utah Change Form

SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS.

Note: For plans purchased through the Federally Facilitated Marketplace (FFM), all requested changes and terminations MUST be processed through the FFM. Visit healthcare.gov or call **800-318-2596**.

A. SUBSCRIBER INFORMATION

Subscriber's Name _____ Subscriber ID# _____ Date of Birth _____
(LOCATED ON ID CARD)

B. SUBSCRIBER INFORMATION CHANGES

Name Changed from _____ Marital Status Change Legally Married Divorced Deceased
 Name Changed to _____ Effective Date of Marital Status Change _____
 New Physical Address _____
 New Mailing Address _____
 City _____ State _____ ZIP _____ New Ph# (____) _____

C. ADD NEW ELIGIBLE DEPENDENTS

NEWBORNS, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION MUST BE ADDED WITHIN 60 DAYS (WHEN THERE'S A CHANGE IN PREMIUM) OF GAINING THE DEPENDENT, OR 31 DAYS (WHEN THERE'S NO CHANGE TO PREMIUM) FROM WHEN THE FIRST CLAIM IS RECEIVED.

FIRST AND LAST NAME	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY NUMBER	TOBACCO USER?
		<input type="checkbox"/> SPOUSE <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED			<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> SPOUSE <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED			<input type="checkbox"/> YES <input type="checkbox"/> NO

D. TERMINATE DEPENDENTS

CHILDREN (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		<input type="checkbox"/> COVERAGE THROUGH OTHER PARENT (DIVORCE) <input type="checkbox"/> GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID, ETC.) <input type="checkbox"/> INDIVIDUAL COVERAGE <input type="checkbox"/> OTHER _____
		<input type="checkbox"/> COVERAGE THROUGH OTHER PARENT (DIVORCE) <input type="checkbox"/> GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID, ETC.) <input type="checkbox"/> INDIVIDUAL COVERAGE <input type="checkbox"/> OTHER _____

SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		<input type="checkbox"/> ANNULMENT <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> COVERAGE ON PARENT'S PLAN <input type="checkbox"/> EMPLOYER GROUP COVERAGE <input type="checkbox"/> GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID) <input type="checkbox"/> OTHER _____

By signing this form, I acknowledge that I will no longer have healthcare coverage through SelectHealth.

Spouse's Signature _____ **Date** _____

E. CANCEL COVERAGE

I hereby request to stop receiving medical benefits received under Contract by SelectHealth®. I understand that this stoppage will be effective on the last day of the month following receipt and approval of this request by SelectHealth. Furthermore, I understand that no cancellation will be made on a retroactive basis.

If you would like a termination date other than the end of the month, write it in the space below.

Date _____

I wish to stop receiving my medical benefits because I am leaving for active military service.

F. SIGNATURE

By signing, you agree to the changes requested above and acknowledge that your monthly premium may change. To terminate coverage, please mark a box in section "E" above before signing.

Subscriber Signature _____ **Date** _____

Change Form Instructions

USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE REQUEST.

*For plans purchased through the FFM, all requested changes and terminations MUST be processed through the FFM. Visit healthcare.gov or call **800-318-2596**.*

SECTION A. SUBSCRIBER INFORMATION

Complete this section using the policyholder's full name and Subscriber ID. You can find this number on your ID card. If you purchased your plan through the FFM, certain changes may be made through the FFM. For more information, contact your SelectHealth-appointed agent or call Individual Sales at **855-442-0220**.

SECTION B. SUBSCRIBER INFORMATION CHANGES

This section is only required for name, marital status, address, or phone number changes.

SECTION C. ADD ELIGIBLE DEPENDENT CHILDREN

Use this section only to add eligible dependents as outlined in your Contract. If you are adding a dependent outside of open enrollment, proof of a qualified life event will be required. Life events that may qualify you for a Special Enrollment Period (SEP) include getting married, having a baby, moving to a new residence, adopting a child, and more. For more information, call Individual Sales at **855-442-0220**.

SECTION D. TERMINATE DEPENDENTS

Use this section to remove your spouse or dependent children. Authorized removal of dependents may be done at any time during the year as long as SelectHealth is notified in advance. For more information, call Individual Sales at **855-442-0220**.

SECTION E. CANCEL COVERAGE

Complete this section if you wish to terminate your policy.

SECTION F. SIGNATURE

Only the subscriber's signature is acceptable. Unsigned change forms cannot be processed and will cause a delay in fulfilling your request.

Submit the completed change form to:

SelectHealth
P.O. Box 30192
Salt Lake City, UT 84130-0192
Fax: **801-442-5798**
Email: individualenrollment@selecthealth.org

When emailing sensitive information, please use your *My Health* account on selecthealth.org.